Department of Medical Assistance Services
600 East Broad Street
Suite 1300
Richmond, VA 23219

https://dmas.virginia.gov
MEDICAID MEMO

**Last Updated: 03/09/2022**

# Implementation of the New Virginia Medicaid Management Information System (MMIS)

This is the final in a series of Medicaid Memos introducing the Department of Medical Assistance Services' (DMAS) new Medicaid Management Information System (MMIS). The new MMIS will provide significant enhancements to better serve our customers, but it will require procedural changes in some areas in order to take advantage of these enhancements. The purpose of this memo is to communicate these changes so that providers can prepare for the transition from our current system to the new MMIS. Additional details will be provided at our upcoming provider training session and in updates to the provider manuals. Also, please watch for updated information in the form of Remittance Advice (RA) messages and updates to the websites listed in this memo. Copies of this Medicaid Memo can be viewed and downloaded from the DMAS website at http://www.dmas.state.va.us.

We apologize for the length of this memo and the amount of information contained in it. However, we are requesting that you take the time to review it carefully, as it contains important information regarding enhanced enrollee eligibility verification options, billing changes and revised claim forms, one-time impacts as we transition to the new MMIS, and HIPAA compliance. **To assist you in locating information of special interest to you, an index of key information is attached as the last page of this memo**.

The official implementation date of the new MMIS is June 20, 2003. However, you will begin to see impacts prior to that date as we make the transition. Although DMAS has made every attempt to minimize impacts on the provider community and make this transition as smooth as possible, certain impacts are unavoidable, and we want to communicate these in advance so that preparations can be made.

## HIPAA READINESS

As communicated in previous Medicaid Memos, the new MMIS will be fully HIPAA compliant when it is implemented on June 20, 2003. Use of the standard HIPAA Transaction Sets and National Codes will be optional until October 16, 2003, at which time, HIPAA formats will become mandatory for all electronic claims. At this time, DMAS is conducting HIPAA testing with trading partners. If you have not yet scheduled testing and are ready to do so, please visit our fiscal agent's, First Health Services Corporation (FHSC), website at http://virginia.fhsc.com. This website contains all of the information needed to schedule and begin conducting the testing. Also, please refer to our Medicaid Memo dated March 26, 2003, for detailed information on this subject. That, and other new MMIS-related memos, can be found on the DMAS website at http://www.dmas.state.va.us.

As a reminder, DMAS will not accept Local Codes for claims, either electronic or paper, with dates of service on or after October 16, 2003. If you submit claims using Local Codes with dates of service on or after October 16, 2003, the claims **will be denied**. DMAS has established a crosswalk to assist you in determining the appropriate National Codes to use in replacing Local Codes. This crosswalk can be viewed on the DMAS website at http://www.dmas.state.va.us.

## PROVIDER ENROLLMENT

You will not have to take any action at this time regarding your enrollment to participate in programs administered by DMAS, **with the possible exception of certain Temporary Detention Order (TDO) providers** . However, the new MMIS is equipped to include additional information regarding you and your practice, and this information will allow us to provide you with better service. After the new MMIS is implemented, we will be mailing new provider enrollment packages to all providers. Execution of the revised forms is necessary in order to fulfill HIPAA requirements and provide DMAS with the additional information needed to improve program operations.

Please note the information below if you participate in the State and Local Hospital (SLH), Family Access to Medical Insurance Security (FAMIS), or Temporary Detention Order

(TDO) Programs.

- Provider numbers for the SLH, FAMIS, and TDO Programs will be the same as the numbers assigned for the Virginia Medicaid Program. DMAS will be able to identify the appropriate program being billed based on the enrollee's eligibility.

- If you are a provider billing for TDO services and you are not enrolled as a Virginia Medicaid provider, you must enroll as a provider in the TDO Program. Upon enrollment, you will be assigned a provider number. You will no longer be able to bill using your FEIN or Social Security Number.

Additional information of interest to Pharmacy providers is included as Attachment 1 to this memo.



**ENROLLEE ELIGIBILITY VERIFICATION OPTIONS**

One of the most significant enhancements of the new MMIS is the availability of additional automated options for use by providers in verifying enrollee eligibility and the provision of more detailed information related to eligibility, claims, and check status.

One of the first changes you will see is the introduction of permanent, plastic enrollee identification cards. The new plastic cards will replace the current paper cards and will no longer require reissuance on a monthly basis. As we make the transition to the new MMIS, the normal paper cards will be issued to enrollees in June 2003 for the month of July 2003. In early July, enrollees will be issued plastic cards, so there may be some time period in July during which enrollees may have both a paper and a plastic card in their

possession. This is a safeguard to ensure that enrollees have an identification card of one form or another during the transition period. Both cards will be valid, and you may accept either one through July 31, 2003. **After July 31, only the plastic cards can be accepted**.

The plastic identification cards offer another important enhancement. The cards are equipped to use "swipe-card technology" and will be encoded with data that will allow you to electronically verify eligibility and receive other information of interest to you. To take advantage of this technology, you will need to contract with an eligibility vendor. There will be some cost to you for this service.

The eligibility vendors are as follows:

| | |
|---|---|
| ProxyMed Inc./MedUnite | (804) 965-6198 |
| HDX | (610) 219-1701 |
| Medifax | (800) 444-4336, ext. 2794 |
| WebMD/Envoy | (941) 575-0632 |
| PayerPath | (804) 560-2400 |
| NDC | (724) 935-5690 |

There are other eligibility options that are available at no cost to you. The automated voice response system, which will be known as **MediCall**, will continue to be available, and it will provide more information than is currently available, including information on pre-authorizations and service limits. The **MediCall** telephone number will be printed on the back of the plastic ID cards. This number is in addition to the current voice response system telephone number, which will remain active.

In addition, DMAS will be introducing a new web-based option for enrollee eligibility verification and claim status information, known as the Automated Response System (ARS). This option is also available free-of-charge, and the information is available in a real-time mode. Information on signing up for this option will be available on the FHSC website at http://virginia.fhsc.com beginning on June 2, 2003. The ARS is secure and fully HIPAA-compliant. When you sign up to use the ARS, you will be

given a password for use in obtaining the necessary information. Staff at FHSC will be available to assist you in signing up to use the ARS and to help with any questions you may have.

These three eligibility verification options will all provide you with the same information. They are designed to give you quick access to current information, even during non-business hours, at little or no cost to you.

## BILLING INSTRUCTIONS AND CLAIMS INFORMATION

**Special Billing Instructions for Pharmacy Providers.** Please see Attachment 1 to this memo for special billing instructions applicable to pharmacy providers.

**Expanded Field Sizes.** A number of fields in the new MMIS will be expanding in order to allow for flexibility for future changes. They are as follows:

| | |
|---|---|
| Provider Identification Number | Expanding from 7 to 9 digits. If you have already been assigned a 7-digit number, you will continue to use that number. |
| Claim Reference Number (ICN) | Expanding to 16 digits. |
| PA Number | Expanding to 11 digits. |
| PA Action Reason Codes | Expanding to 4 digits. |
| Adjustment/Void Reason Codes | Expanding to 4 digits. The current "5" will be replaced by a "10" and the last 2 digits will remain the same, e.g., 552 will become 1052. |

| | |
|---|---|
| Error Reason Codes | Expanding to 4 digits. Error Reason Codes will appear on the Remittance Advice (RA). In addition, new error messages have been added to the RAs, incorporating the National Standard EDI Adjustment Codes and Remark Codes. There will be a transition period during which both the DMAS proprietary error reasons and the National Standard Reason and Remark Codes will be printed on the paper RA. |

**CMS-1500 (12/90) Claim Form.** The following are new instructions for completion of certain fields on the CMS-1500 claim form:

- **Block 24G.** Minutes billed should be specified in the "days or units" field only. Do not bill fractional hours.

- **Block 33.** Enter the Virginia Medicaid provider servicing number in the PIN# field and the billing provider number in the GRP# field. If the servicing and billing providers are the same, leave the GRP# field blank. Also, ensure that the provider numbers are distinct and separate from the telephone number or zip code.



- **HMO Copayments.** When billing for the copayment for Medicaid enrollees who have a Health Maintenance Organization (HMO) as their primary insurer, use COB code “3” in locator 24J. **Do not enter an amount in locator 24K. “HMO Copay” must be entered in locator 11C.** The amount billed to Medicaid in Block 24F (Charges) must represent only the enrollee’s copayment amount for the HMO, and the Explanation of Benefits (EOB) must be attached. **Use the CPT or HCPCS procedure code that was billed as the primary procedure to the HMO.** This does not apply to

enrollees in a Medicaid HMO, e.g., Medallion II. The Medicaid copayment amount will apply to office visits. Therefore, a Medicaid copayment will be deducted from the HMO copayment billed. For example: A Medicaid enrollee with HMO primary insurance may have a

$10.00 copayment for an office visit. Medicaid's copayment for the office visit is $1.00. Therefore, Medicaid's allowance will be $9.00 for this office visit. The remaining $1.00 should be collected from the enrollee at the time of the service. For electronic data interchange (EDI) claims filers, please refer to the EDI companion guide. Companion guides can be found on the FHSC website at http://virginia.fhsc.com.

**UB-92 (CMS-1450) Claim Form.** Changes for claims submitted on the UB-92 are the result of changes made by the National Uniform Billing Committee (NUBC). They are as follows:

- Revenue codes have been expanded to 4 digits. Providers should submit the appropriate revenue codes for the services provided. The revenue codes accepted for each provider class type will be attached to their specific provider manual billing updates. Leading zeroes must be inserted in 3-digit codes that have not been expanded by the NUBC.

- Bill types that indicate a claim adjustment will no longer be indicated by the third digit of "6" (e.g., 116, 136). The appropriate third digit is "7" (e.g., 117, 137).

- DMAS will accept all standard National Codes from CPT/HCPCS, ICD-9-CM for diagnosis, procedure, condition, and occurrence codes.

- Services (inpatient admissions, rehabilitative services, home health) that require pre-authorization (PA) must have the assigned PA number included on the claim. The PA number is placed in locator

  63. **Claims will be denied if a PA is required for the service, and the number is not included on the claim.**

In addition, the following changes apply to nursing facilities:

- The bill types for Intermediate Care Facilities will change from 811 (original), 816 (adjustment), and 818 (void) to 611 (original), 617 (adjustment), and 618 (void).



- The patient status codes for locator 22 will be changed to accept standard National Codes. The frequently used status codes are listed below. Please refer to the NUBC manual for a complete listing.

01 = discharged to home or self care.

02 = discharged to another short term general hospital for inpatient care. 03 = discharged/transferred to skilled nursing facility (SNF).

04 = discharged/transferred to intermediate care facility (ICF).

05 = discharged/transferred to another institution for inpatient care or referred for outpatient services to another institution.

07 = left against medical advice or discontinue care. 20 = expired.

The **Comprehensive Services Act (CSA) Reimbursement Rate Certification form** (DMAS 600) has been revised. It is available for download from the DMAS website at http://www.dmas.state.va.us.

**Title XVIII (Medicare) Deductible and Coinsurance Invoice Form.** DMAS has revised its Title XVIII (Medicare) Deductible and Coinsurance Invoice form (DMAS – 30 R 6/03). The revised claim form will allow submission of claims for one recipient per form only. The new form will facilitate the data entry process and increase the accuracy of claims processing. This, in turn, should significantly reduce errors and speed claims

payment. This form is specific to the Virginia Medicaid Program, and other Title XVIII claim forms will not be accepted. **The revised claim form must be used for all paper claims postmarked after May 30, 2003. However, do not use it before that date. Do not use any existing claim forms that you may have in your stock after this time. The only claim form that will be accepted for claims postmarked after May 30, 2003 is the DMAS-30 R 6/03.** An example of this form is included in Attachment 5 to this memo. It is available for downloading from the DMAS website at http://www.dmas.state.va.us. The current Title XVIII Adjustment Form (DMAS-

31. will continue to be used for adjustments.

**Claims Turnaround Documents.** A turnaround document (TAD) will replace the blue reject letters currently sent by FHSC. If a claim cannot be processed due to missing or invalid data on the claim submitted, you will receive a system-generated TAD. The TAD must be returned to FHSC with the requested information. The claim will be denied if the TAD is not returned and corrections entered in the system within 21 days. Please allow sufficient time for entering corrections into the system (48 hours) and mail time when returning TADs. Only the requested information should be returned. Additional information will not be considered and may cause the claim to be denied. A sample of the new TAD is included in Attachment 5 to this memo.

**Electronic Billing Attachment Form.** A new attachment form (DMAS-3) will be available for use by electronic billers **only** to submit a non-electronic attachment to a claim submitted electronically using the X12N 837 claims transaction. An Attachment Control Number (ACN) must be entered on the



electronic claim submitted. The ACN consists of the combined fields of the patient account number, date of service, and the sequence number. (See the FHSC website at http://virginia.fhsc.com for electronic claim transmission specifications). **IMPORTANT:** THE ACN ON THE DMAS-3 FORM MUST MATCH THE ACN ON THE CLAIM, OR THE ATTACHMENT WILL NOT BE MATCHED TO THE CLAIM SUBMITTED. IF NO MATCH IS FOUND, THE CLAIM MAY BE DENIED. ATTACHMENTS MUST BE SUBMITTED

AND ENTERED INTO THE SYSTEM WITHIN 21 DAYS, OR THE CLAIM MAY RESULT IN A DENIAL. PLEASE ALLOW SUFFICIENT TIME FOR ENTERING DATA INTO THE SYSTEM (48 HOURS) AND MAIL

TIME WHEN SUBMITTING THE DMAS-3. A sample of the DMAS-3 is included in Attachment 5 to this memo. Copies of the DMAS-3 may be downloaded from the DMAS website at http://www.dmas.state.va.us.

**Maternity and Infant Care Coordination Record.** The current Maternity Care Coordination Record (DMAS-50) and the Infant Care Coordination Record (DMAS-51) have been combined into a single form now known as the Maternal and Infant Care Coordination Record (DMAS-50 rev 06/03). Detailed instructions on completing this form are printed on the back of the form (copy included in Attachment 5 to this memo). For your convenience, elements that apply to both maternity and infant clients are in regular typeface. Elements relating only to maternity clients appear in *italics*. Elements relating only to infant clients appear in **Bold**. There is no change in the process for submitting your admission packets, Outcome Reports, and change forms. You must begin using the new Care Coordination Record on May 30, 2003. The new DMAS-50 may be downloaded from the DMAS website at http://www.dmas.state.va.us.

The BabyCare program is now part of DMAS' Division of Health Care Services. To ensure prompt attention to your paperwork, please direct information to:

BabyCare Program

Department of Medical Assistance
Services 600 E. Broad Street, Suite
1300

Richmond, VA 23219

Do not send claims to the above address. Claims should always be sent directly to FHSC. Sending claims to the above address increases the time it takes to process your claims.

**Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs).** For Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) that have dental clinics associated with them, the Local Code 00088 will no longer be valid for

claims with dates of service on or after October 16, 2003. For claims with dates of service on or after October 16, 2003, bill Medicaid using one of the standard Current Dental Terminology (CDT-4) codes (either D0120 or D0150) for dental examinations. You will continue to bill the dental visit "encounter" on the American Dental Association claim form, ADA (1994) Claim Form.



**Emergency Transportation Providers.** Local Codes that begin with "Y" will no longer be valid for claims with dates of service on or after October 16, 2003. For claims with dates of service on or after October 16, 2003, bill Medicaid using the following crosswalk:

| Local Code | New HCPCS Code |
|---|---|
| Y0109 | A0225 |
| Y0110 | A0427 |
| Y0110 | A0429 |
| Y0121 | A0430, A0431, or A0999 |

**Vaccine Billing Information.** Effective for claims with dates of service on or after October 16, 2003, you will no longer use the Local "Y" Codes when billing Medicaid for the administration fee for vaccines provided under the Vaccines for Children (VFC) Program. Claims with dates of service on or after October 16, 2003 must be submitted with the Current Procedural Terminology (CPT) code that describes the vaccine provided. For a vaccine provided to a Medicaid child, you should use the applicable CPT code to reflect the administration fee and bill $11.00 for the charge. You will be reimbursed $11.00. For a vaccine provided to a FAMIS enrollee, you should also bill the CPT code, but your charge should reflect both the acquisition cost for the vaccine provided **PLUS** the $11.00 administration fee. For these enrollees, you will be reimbursed the lesser of the most current acquisition cost plus $11.00 or actual charges for these enrollees.

Providers must use Current Procedural Terminology (CPT) codes when billing for either the administration fee or acquisition cost (FAMIS enrollees only) for vaccines. When a CPT code is billed to reflect a vaccine provided under the VFC program to a Medicaid enrollee, an $11.00 administration fee will be paid regardless of the CPT code billed. NOTE: It is **extremely important** to bill the correct CPT code that reflects the vaccine provided, as this assists the Virginia Department of Health (VDH) with their accountability plan which is required by the Centers for Medicare and Medicaid Services (CMS). For FAMIS enrollees, in addition to the $11.00 administration fee reimbursement, you will also be reimbursed the most recent acquisition cost that DMAS has on file for the vaccine.

Example 1: You are billing Medicaid for a Hepatitis B vaccine provided to a child covered under the VFC Program. Use code 90744. Payment will be $11.00 (administration fee only).

Example 2: You are billing Medicaid for a Hepatitis B vaccine provided to a child covered under the FAMIS Program. Use code 90744 (bill only one line). Payment will be the lesser of the most recent acquisition cost on file **PLUS** the $11.00 administration fee, or actual charges.



NOTE: For FAMIS enrollees and for other enrollees ages 19 and 20, physicians will be reimbursed an appropriate minimal office visit (e.g., CPT code 99211) in addition to the administration fee and/or acquisition cost as appropriate when an immunization is the only service provided.

For questions concerning the VFC Program, please contact VDH, Department of Immunizations, at 1- 800-568-1929.

**Ambulatory Surgical Centers.** The facility fee for the use of the Ambulatory Surgery Center (ASC) should be billed by using the Current Procedural Terminology (CPT) code that describes the surgery performed. Medicaid is using the most recent ASC group listings as defined by Medicare. For the most recent listings, see the Medicare website (www.cms.gov). If you are billing for a procedure that is not included in these listings, your claim will pend and will be manually reviewed for payment. Remember that the fee that is reimbursed to ASCs is for facility use and necessary equipment only. The physician performing the surgery will be reimbursed separately by billing the CPT code that describes the surgery performed. The reimbursement rate for physicians is based on the Resource Based Relative Value Scale (RBRVS). The reimbursement rate for facilities is based on fees established by DMAS. Your payment will be determined based on the ASC Group in which the procedure falls. See the crosswalk chart below:

**Crosswalk from Previous "M" Codes to ASC Group Listings**

| Old Code | ASC Group | Payment to Facility |
|---|---|---|
| M0050 | Group 1 | $277.44 |
| M0051 | Group 2 | $371.52 |
| M0052 | Group 3 | $426.05 |
| M0053 | Group 4 | $524.83 |
| M0054 (formerly used as an unlisted code for surgeries not found in other ASC Groups) | Group 5 | $599.14 |
| No previous code | Group 7 | $869.14 |

NOTE: While Medicare has established a payment rate for ASC Group 6, there are no procedures that fall under this group at the present time.

If you are billing for two surgeries performed on the same day that fall under the same ASC Group Listing, Medicaid will reimburse the facility-use fee at the rate of 100 percent for the first surgery and 50 percent for the second surgery. If you are billing for surgeries that fall under different ASC Group Listings, the ASC will be paid 100 percent of the facility-use fee for the surgery with the higher payment level and 50 percent for any additional surgeries.

**Optical Character Recognition.** FHSC utilizes Optical Character Recognition (OCR), a technology which permits the recognition and capture of printed data. Through the use of OCR, claims are entered



into the processing system more rapidly. In addition, OCR minimizes manual intervention required to correctly process claims. Successful scanning begins with the proper submission of claims data. Printed characters must conform to pre-programmed specifications relative to character size, density, and alignment on the CMS-1500 (12/90) and UB92-1450 forms. Only the original CMS-1500 (12/90) and UB92-1450 forms with the proper red dropout ink (PMS# J6983) are acceptable for OCR (Optical Character Recognition). Guidelines to ensure proper processing of paper claims submission are included in Attachment 2 to this memo. Adherence to these guidelines will increase the accuracy of claims processing and facilitate claims payment. Handwritten claims forms are still acceptable, but the processing time for these claims may be increased.

## MEDICAL PRE-AUTHORIZATION PROCESS

Pre-authorization (PA) is required for a number of services that are reimbursed by DMAS. Implementation of the new MMIS will impact the medical pre-authorization process. Where noted, there will be attachments for your records and use. The following sets forth the most significant changes to the PA process:

- PA numbers will be expanded from 9 to 11 digits. The PA number is **required** on the claim form when billing for an authorized service.

- PA Action Reason Code numbers will be expanded from 3 to 4-digit numerical codes followed by the reason code narrative.

- If you are requesting pre-authorization utilizing the "paper" process for services such as DME and supplies, home health, and outpatient rehabilitation, you must utilize the revised DMAS-351 R 06/03 form for requests postmarked after May 30, 2003. Supporting medical documentation should be attached to the completed form when submitting an original or change request. You may also request a PA cancellation utilizing the DMAS-351. A copy of this form, with instructions for completion, is included in Attachment 5 to this memo, and it is available for downloading from the DMAS website at http://www.dmas.state.va.us. Use the revised DMAS-351 form only for claims postmarked after May 30, 2003. Attachment 3 to this memo contains a listing of PA Service Types that are needed to complete this form.

- When additional supporting documentation is required in response to a "pend" response message, you must utilize the new DMAS-361 form as a cover sheet for the documentation. The DMAS-361 form can also be used to request reconsideration of a PA denial. Please refer to the appropriate provider manual for required reconsideration timeframes for submission. A copy of the new DMAS-361 is included in Attachment 5 to this memo, and can be downloaded from the DMAS website. Use the new DMAS-361 form only for claims postmarked after May 30, 2003.



- Effective July 1, 2003, PA will be required for home health skilled nursing and home health rehabilitation, as well as rehabilitation services, including physical therapy, occupational therapy, and speech therapy, prior to the sixth visit. If authorization is not obtained prior to the sixth visit, authorization will not be retroactive.

- **Effective July 1, 2003, service limits for outpatient psychiatric services in the first year of treatment will decrease to 5 visits. Prior to sixth visit, the provider must contact DMAS to obtain authorization for**

**additional therapy sessions. If pre -authorization is not obtained prior to the sixth visit, authorization will not be retroactive.**

- Dental providers will utilize the ADA (1994) Claim Form to request PA for dental/orthodontic services. The transmission code to be used is "180" in Block 3 of the form. Dentists can utilize the DMAS-351 form when requesting changes or deletions to a PA request, and the DMAS- 361 form as the cover sheet for supporting documentation needed in response to a "pend" or if you are sending orthodontic models separate from the PA request. If known, the PA number should be included on the DMAS-361 form.

## REMITTANCE ADVICE

The Remittance Advice (RA) has been re-designed to provide additional information to you. Examples of revised RAs are included as Attachment 4 to this memo. The examples provide guidance on how to read the new RAs. In addition, if you bill electronically using the HIPAA-prescribed 837 transaction set, you will receive an electronic RA in the form of the HIPAA-prescribed 835. For the first three months you receive the 835, you will also receive a paper RA. At the end of this period, you will receive an electronic 835 RA only.

## CALENDAR OF TRANSITION EVENTS

The following is a calendar illustrating the remittance cycle dates during and after our transition to the new MMIS:

| Cycle | Processing Cycle Date | Payment Date |
|---|---|---|
| Last cycle on current system | 06/13/03 | 06/20/03 |
| First cycle on new MMIS | 06/20/03 | 07/03/03* |
| Second cycle on new MMIS | 06/27/03 | 07/11/03 |
| Third cycle on new MMIS | 07/04/03 | 07/18/03 |
| Fourth cycle on new MMIS | 07/11/03 | 07/25/03 |

Processing and payment cycle dates continue accordingly.

*Electronic Funds Transfer (EFT) payments will also be available on July 3, 2003.



As DMAS makes the transition to the new MMIS, there are some key dates and events of which you need to be aware. Please review the following events carefully as they will impact the time frames for making procedural changes and may impact DMAS' ability to process claims submitted. The events are listed in chronological order.

**May 16, 2003** Claims which would normally be pended for additional information will be denied.

**May 30, 2003** Deadline for postmark of claims using the current versions of the paper pharmacy and Title XVIII claim forms. Paper claims postmarked after this date must be on the new claim forms, including resubmission of rejected claims. See the "Billing Instructions and Claims Information" section of this memo. Pharmacy providers see separate Medicaid Memo dated April 16, 2003.

EFT enrollments will be temporarily stopped. Enrollments will resume on July 3, 2003.

Deadline for HMOs to submit encounter claims in the current format. Claims submitted after this date must use the 4010 version of the

837, with addenda, i.e., ASC X12N 837.

**June 2, 2003** Registration to use the eligibility verification Automated Response System (ARS) begins.

**June 6, 2003** All claims in a pend status on June 13, 2003 will be denied in the June 20, 2003 remittance cycle. These claims must be re-submitted as new claims using any applicable revised instructions contained in this memo for claims submitted for processing by the new MMIS. Electronic claims in National Standard Formats may be resubmitted on or after June 16, 2003. Electronic claims in HIPAA- mandated formats may be submitted on or after June 20, 2003. NOTE: If you are an Emergency Department (hospitals and physicians) submitting emergency room claims electronically, **do not** submit these claims after May 16, 2003 if you think they may suspend.

**June 11, 2003** Electronically-submitted claims must be submitted by 6:00 a.m. in order to be processed in the June 20, 2003 remittance cycle (payment date).

Deadline for submission of POS pharmacy claims if they are to be included in the June 20, 2003 remittance cycle (payment date).

**June 13, 2003** Pre-authorization (PA) requests will not be processed.

All claims processed in the June 13, 2003 remittance cycle will either deny or pay on the remittance dated June 20, 2003. Claims that would ordinarily pend will be denied. These claims must be re-submitted as new claims using any applicable revised instructions contained in this memo for claims submitted for processing by the new MMIS.

**June 16, 2003** Production of plastic ID cards for new enrollees begins.

**June 20, 2003** HIPAA-compliant transactions will be accepted. National Codes can be used for all HIPAA-compliant transactions. See the DMAS website at http://www.dmas.state.va.us for a crosswalk of Local Codes to National Codes.

**July 7, 2003** Production of plastic ID cards for existing enrollees begins.

**October 16, 2003** Electronic billers must use HIPAA-compliant transactions for claims submitted on or after this date. Local Codes will not be accepted for claims (electronic or paper) with dates of service on or after this date.

## PROVIDER TRAINING

DMAS will be offering training on the new system enhancements to all interested providers. The training will be held on June 5, 2003 and will be performed via teleconference. DMAS will host ten sites statewide in order to make the training accessible to all who have an interest. Registration information will be forthcoming. Continue to watch DMAS' Learning Network at http://www.dmas.state.va.us for updated information.

**COPIES OF MANUALS**

DMAS will be updating its provider manuals to reflect the new MMIS and HIPAA-related changes. The manuals and manual up-date transmittals will be posted on our website at http://www.dmas.state.va.us as they become available. Please watch for Remittance Advice messages announcing availability of revised manuals.

Provider manuals and transmittals can be viewed on, and printed from, the DMAS website. The transmittals describe the updated materials and manual chapters and pages revised. For a list of updates, click on "up-date transmittals" in the "Provider Manuals" column. If you do not have access to the Internet, or would like a paper copy of a manual, you can order them by contacting



Commonwealth-Martin at 804-780-0076. A fee will be charged for the printing and mailing of the manuals and manual updates requested.

**"HELPLINE"**

The "HELPLINE" is available Monday through Friday from 8:30 a.m. to 4:30 p.m., except State holidays, to answer questions. The "HELPLINE" numbers are:

786-6273
Richmond area
1-800-552-8627
All other areas

Please remember that the "HELPLINE" is for provider use only.